



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Suspicious Death St. Louis VA Medical Center St. Louis, Missouri

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Executive Summary

The purpose of the review was to determine the validity of an allegation that a suspicious death occurred at the St. Louis VA Medical Center. The complainant alleged that staff disconnected the patient from a ventilator, resulting in death; and that physicians coerced the complainant into changing the patient's resuscitation status.

We did not substantiate the allegation that staff removed the patient from mechanical ventilation, resulting in his death. We determined that the patient received aggressive and appropriate medical treatment during his hospitalization. The patient had severe lung disease with a history of lung cancer and chronic pneumonitis following radiation therapy. Physicians placed the patient on mechanical ventilation following a respiratory arrest, and he remained on mechanical ventilation until he was pronounced dead. An autopsy attributed his death to "respiratory failure and pneumonia in a patient with underlying chronic obstructive pulmonary disease."

We did not substantiate that the complainant was coerced to change the patient's resuscitation status from full code (requested full life support) to Do Not Resuscitate (DNR). The patient had designated himself as a full code but when his condition continued to worsen and he became nonresponsive, physicians spoke to the complainant about changing the code status. We found no evidence or reason for coercion. Physicians did write a DNR order the day before the patient's death but continued to treat the patient aggressively. However, medical staff did not enter a progress note at the time the DNR order was written. According to medical center and Veterans Health Administration (VHA) DNR policies, a progress note should have documented the diagnosis and prognosis; consensual decisions and recommendations of the treatment team and consultants, with documentation of their names; an assessment of the patient's competency; and, because this patient was incompetent, the wishes of the patient's representative and documentation of the relationship of the patients' representative. Because of the lack of required documentation, we were unable to determine the course of events that led to the change in code status and the communication with the complainant. Furthermore, the medical center DNR policy was not reviewed for compliance with more recent VHA DNR protocols in September 2004 as scheduled.

We recommended that management update the DNR policy and educate all clinical staff on DNR protocols.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network (10N15)

SUBJECT: Healthcare Inspection — Alleged Suspicious Death, St. Louis VA Medical Center, St. Louis, MO

Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections (OHI), conducted an inspection to determine the validity of an allegation that a suspicious death occurred at the VA Medical Center (the medical center), St. Louis, MO.

Background

The medical center is a two-division, tertiary care facility in Veterans Integrated Service Network (VISN) 15. The John Cochran (JC) division is located in downtown St. Louis, and the Jefferson Barracks (JB) division is located in south St. Louis County. The JC division has 116 acute care beds and provides acute medical and surgical programs with a wide range of specialty care. The JB division provides primary care and has 102 acute beds (70 psychiatry and 32 spinal cord injury), a 50-bed domiciliary, and a 71-bed nursing home.

A complainant, the brother of the deceased patient, specifically alleged that:

- Staff disconnected the patient from a ventilator, resulting in his death.
- Physicians coerced the complainant into changing the patient's resuscitation status.
- The patient's belongings were stolen during his hospitalization.

Scope and Methodology

We conducted a site visit on January 17–19, 2007. Prior to our visit, we interviewed the complainant in order to clarify the initial written allegations received by the OIG. We interviewed medical center administrative and clinical staff, including physicians, nurses,

and a social worker. We reviewed medical and administrative records; quality management documents; and medical center and VHA policies and procedures. We conducted the review in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

The allegation of stolen patient belongings has been referred to the medical center for review. There is documentation that when he was admitted nurses inventoried the patient's belongings and asked him to surrender them for safe keeping. He refused and signed a report of contact indicating that he would be responsible for any lost valuables or funds. The medical center police never received a report of missing valuables.

Inspection Results

Clinical Case Review

The patient was a 74-year-old male with a complex medical history that included stage IV (metastatic) non-small cell lung carcinoma, radiation pneumonitis, pneumonia, chronic obstructive pulmonary disease (COPD), and melanoma. The patient had a smoking history of two packs of cigarettes per day for at least 50 years, until he quit in 2002.

The patient had a 30-year history of a chronic right lung nodule that clinicians had followed by chest x-ray. A chest x-ray on October 2, 2001, again showed the small nodule and his physician recommended rechecking in 6 months. On June 4, 2002, a physician saw the patient for a routine appointment in geriatric clinic. At that time, the physician offered the patient the option of a computerized tomography (CT) scan to assess the nodule. The July 12, 2002, CT scan indicated that the patient had a large right upper lobe lung mass with multiple nodules suggestive of carcinoma with metastasis and a left lung lesion.

On August 12, 2002, the patient was admitted to the medical center for a CT guided lung biopsy to determine pathology of the lung mass. The patient developed a pneumothorax (partial lung collapse) after the procedure and required chest tube placement for re-expansion. He was discharged home the next day, pending pathology results.

The pathology was positive for carcinoma and the patient received concurrent chemotherapy and radiation treatments starting September 3, 2002. Although he was unable to complete his full course of chemotherapy because of decreased blood counts, he completed his radiation treatments on October 22, 2002. The patient subsequently developed radiation pneumonitis/fibrosis and physicians treated him with antibiotics on an outpatient basis.

On December 18, 2002, the patient was admitted to the medical center for progressively worsening shortness of breath over the previous 2 weeks. Physicians began steroid

therapy and completed antibiotics for his pneumonitis. They noted the condition may be chronic as a result of his radiation therapy, but the carcinoma had responded to treatment. During that hospitalization, he reported to the social worker that he had an advanced directive completed by his private attorney. The social worker asked him to submit a copy for the medical record but the patient stated that his attorney advised him not to provide a copy. He was discharged home on December 20.

From January 2003 through June 2005, the patient received follow-up care in outpatient clinics and remained relatively stable. In June 2005, the patient had an ear lesion resection for melanoma. Clinicians continued to follow the patient in outpatient clinics.

On April 17, 2006, the patient was admitted to the medical center for hypoxia (insufficient oxygen) and shortness of breath. He had a diagnostic chest x-ray and a CT scan which indicated severe lung disease. Pulmonologists performed a bronchoscopy on April 20, which revealed pneumonia with no evidence of cancer recurrence. The patient was discharged home on April 24 with a consult for community health nursing for medication management and supervision of home oxygen therapy.

On May 25, 2006, the patient went to the medical center emergency room (ER) for shortness of breath and cough with occasional sputum. He received respiratory treatments, laboratory tests, and a chest x-ray. His condition improved and he returned home the same day.

On July 7, 2006, the patient was brought to the medical center ER for worsening shortness of breath on exertion. ER clinicians administered a respiratory treatment which improved his breathing and he returned home with medications.

The patient was transferred from a private facility ER to the medical center ER on July 21. He was admitted to the medical intensive care unit (MICU) for worsening shortness of breath and pain in the right shoulder and back. He received respiratory treatments and antibiotics. Physicians noted that he was a full code, meaning if he had a respiratory or cardiac arrest he would be resuscitated. He was transferred to a medical unit on July 23. The patient's condition stabilized and on July 28, physicians transferred him to rehabilitative service. During the rehabilitative stay, the patient's respiratory status was determined to be slowly declining.

On August 16, 2006, he became lethargic and confused. He experienced respiratory distress and was transferred to the medical center ER for treatment. He was admitted to a medical unit with the diagnoses of COPD exacerbation and bronchitis. On August 17, nursing staff found the patient unresponsive and initiated cardiopulmonary resuscitation. Physicians determined the respiratory arrest was most likely due to a mucous plug or aspiration. The patient was transferred to MICU, where he was intubated and placed on a ventilator.

On August 22, the complainant, medical staff, and a social worker met with the patient in his room to discuss the plan of care. The resident physician asked the patient if he wanted to have a tracheostomy placed for his long term ventilation needs or if he would rather have care withdrawn. While the patient remained intubated, he used head and hand gestures to indicate that he wished to have a tracheostomy placed and to continue with full treatment. The patient indicated his desire to remain a full code. The resident physician consulted Otolaryngology for tracheostomy placement. Otolaryngology determined that the tracheostomy was appropriate and scheduled the patient for the surgical procedure. Because the patient was sedated for comfort, the complainant gave verbal consent for the tracheostomy. The patient remained a full code and the tracheostomy was performed on August 29.

On August 30 at approximately 6:30 a.m., the patient developed a rapid, abnormal heart beat and was unresponsive. Clinicians continued to aggressively treat the patient. The resident physician spoke with the complainant about the patient's worsening condition and poor prognosis. The resident physician noted that the complainant was not ready to withdraw care based on the patient's wishes prior to becoming unresponsive. At 4:30 p.m., the resident physician wrote a Do Not Resuscitate (DNR) order. At 6:30 p.m., the pulmonary fellow spoke to the complainant about the patient's poor prognosis and documented the change in the patient's code status to DNR. The patient required increased oxygenation and frequent suctioning on mechanical ventilation.

On August 31 at 2:55 a.m., a respiratory therapist obtained a blood sample for arterial blood gas testing. At 5:49 a.m. a portable chest x-ray was completed and the report indicated that the patient was intubated and on the ventilator. The patient's condition continued to deteriorate until he did not have pulse. Nurses contacted the resident physician who pronounced the patient dead at 7:00 a.m. An autopsy was completed with death attributed to respiratory failure and pneumonia in a patient with underlying chronic obstructive pulmonary disease. There was no evidence of residual carcinoma.

Issue 1: Disconnection from Ventilator Support

We did not substantiate that the patient was disconnected from ventilator support. The complainant alleged that this caused the patient's death.

The MICU progress notes and orders document that the patient received aggressive therapy including antibiotics for his infection, a feeding tube for nutrition, a tracheostomy for anticipated long term ventilator support, continuous intensive care monitoring, and additional diagnostic testing. Clinicians stated the patient was not disconnected from the ventilator. Ventilator flow sheets and MICU nurse flow sheets document checks for ventilator settings and properly functioning alarms from August 17 through August 31, 2006.

We found no indication that the patient's death was the result of discontinuation of the ventilator or inadequate medical care. Physicians reported that the patient's prognosis was poor due to advanced lung disease but that the plan of care was for long term ventilator support. Mechanical alarms remained functional and the patient remained on the ventilator at the time of his death.

Issue 2: Coercion to Change Code Status

We did not substantiate the allegation that the complainant was coerced to change the patient's code status from full code to DNR.

The complainant alleged that there were multiple telephone calls on August 30 to pressure him into changing the patient's code status to DNR. The complainant stated that the medical resident called him two times and another physician called him once. The medical record documents two interactions between the complainant and the physicians.

The first interaction occurred on August 30, 2006, at approximately 11:00 a.m. when the resident physician spoke to the complainant about the patient's poor condition and prognosis. At that time the complainant was not ready to withdraw care based on the patient's previous wish to remain a full code. The resident physician wrote an order for DNR at 4:30 p.m. but did not write an accompanying progress note.

The second interaction occurred at approximately 6:30 p.m. when the pulmonary fellow spoke with the complainant. The pulmonary fellow documented his discussion with the complainant concerning the patient's poor prognosis and included the code status change to DNR.

Clinicians agreed they spoke with the complainant on multiple occasions throughout the hospitalization about the patient's poor prognosis and code status. The attending physician stated he had spoken with the complainant about the patient's condition. He felt the communication was effective and that the complainant was pleased with the patient's care. During the course of the patient's hospitalization, the complainant did not voice dissatisfaction with care. Clinicians agreed that they discussed the patient's poor prognosis with the complainant and code status. They stated that if there would have been a conflict in determining code status, they would have contacted the medical center Ethics Committee. They did not feel this was necessary based on their interactions with the complainant.

We concluded that physicians did contact the complainant to discuss the patient's prognosis and code status but there was no evidence or reason for coercion to change code status.

Issue 3: Compliance with DNR Policies

During our inspection, we found that clinicians did not follow medical center and Veterans Health Administration DNR policies.

The medical center DNR policy¹ requires that at the time a DNR order is written, a companion entry will be made in the medical record. This note should include, at a minimum: the diagnosis and prognosis; the consensual decisions and recommendations of the treatment team and consultants, with documentation of their names; the assessment of the patient's competency; and the competent patient's wishes, or in the cases involving an incompetent patient, the patient's wishes as understood by a designated Surrogate Decision Maker (SDM); and the relationship of the patient's SDM to the incompetent patient. The policy also states that the attending physician must either write the DNR order or, at a minimum, cosign the order. The attending physician is responsible for ensuring that the order and its meaning are discussed with appropriate members of the medical center staff so that all involved professionals understand the order and its implications.

On August 30, 2006, at 11:11 a.m., the resident physician wrote a progress note documenting full code status and the fact that the complainant was not ready to withdraw care. The resident physician wrote an order for DNR on August 30 at 4:30 p.m. However, he did not write a companion progress note. The pulmonary fellow wrote a progress note at 6:30 p.m. acknowledging the change from full code to DNR.

The attending physician co-signed the 11:11 a.m. resident progress note documenting full code status at 5:03 p.m. The attending physician wrote an order for DNR on August 31 at 1:02 a.m. He did not write a companion progress note but co-signed the pulmonary fellow's August 30, 6:30 p.m. progress note at 1:01 a.m. The attending stated he co-signed these notes early in the morning because he was called for an admission and the electronic medical record automatically brings up unsigned notes for signature.

We concluded that actions did not comply with local and VHA² documentation and communication requirements. Because of the lack of required documentation, we were unable to determine the course of events that led to the change in code status and the communication with the complainant.

In addition to the above finding, the medical center policy is dated September 5, 2001, and was due for review on September 5, 2004. Medical center managers should have reviewed the policy for compliance with more recent VHA protocols.

¹ Medical Center Memorandum 11-20, *Guidelines for Do Not Resuscitate (DNR) Procedures*, September 5, 2001.

² VHA Handbook 1004.3, *Do Not Resuscitate (DNR) Protocols Within the Department of Veterans Affairs (VA)*, October 24, 2002.

Conclusion

During the course of his hospitalization, the patient received aggressive and appropriate medical treatment. His respiratory status was supported by mechanical ventilation without interruption until he was pronounced dead. We did not substantiate the allegation of coercion to change the code status. However, we found that the medical staff did not follow medical center and VHA DNR policies. While this did not affect this patient's care, it reflects a system problem that has the potential to affect others.

Recommendation 1. We recommended that the VISN Director require the Medical Center Director to update the DNR policy.

Recommendation 2. We recommended that the VISN Director require the Medical Center Director to educate all clinical staff on DNR protocols.

Comments

The VISN and Medical Center Directors concurred with the findings and recommendations of this inspection and provided acceptable improvement plans (see Appendixes A and B, pages 8–10, for the full text of the Directors' comments). We will follow up on the planned actions until they are completed.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 25, 2007

From: Director, Veterans Integrated Service Network (10N15)

Subject: **Healthcare Inspection, Alleged Suspicious Death, St. Louis VA Medical Center, St. Louis, Missouri**

To: Director, Kansas City Office of Healthcare Inspections
(54KC)

Director, Management Review Office (10B5)

I have reviewed and concur with the action plan to the recommendations as outlined by St. Louis VAMC.



PETER L. ALMENOFF, MD, FCCP

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 17, 2007

From: Director, St. Louis VA Medical Center (657/00)

Subject: **Healthcare Inspection, Alleged Suspicious Death, St. Louis VA Medical Center, St. Louis, Missouri**

To: Director, Veterans Integrated Service Network (10N15)

Attached is the St. Louis VA Medical Center's response and action plan to the Healthcare Inspection of an Alleged Suspicious Death.

(original signed by:)

GLEN E. STRUCHTEMEYER

**Director's Comments
to Office of Inspector General's Report**

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

OIG Recommendation(s)

Recommendation 1. We recommend that the VISN Director require the Medical Center Director to update the DNR policy.

Concur **Target Completion Date:** June 4, 2007

The St. Louis VA Medical Center will update the DNR policy.

Recommendation 2. We recommend that the VISN Director require the Medical Center Director to educate all clinical staff on DNR protocols.

Concur **Target Completion Date:** June 30, 2007

The St. Louis VA Medical Center will provide training to the clinical staff on DNR policy and procedures.

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana, Director Kansas City Regional Office of Healthcare Inspections (816) 426-2023
Acknowledgments	Dorothy Duncan Reba Ransom James Seitz Marilyn Stones George Wesley, M.D.

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